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Abstract

The report of a symposium on continuing medical education in Montana, sponsored by the WICHE Mountain States Regional Medical Program, presents summaries of speeches of four consultants who discussed the following topics: How Can an Interprofessional Program Be Developed?; Continuing Medical Education Problems, Priorities, and Plans; Can Health Professions Work and Learn Together?; and "Communication Problems Affecting Patient Care." Also included are general remarks on two general discussion sessions: "The Strategy of Interprofessional Continuing Education Development in Montana", and "The Development of a Plan for Continuing Medical Education in Montana," which focused on a proposed research and education foundation authorized in March, 1968 by the Montana Medical Association. (nl)

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ED033306

A SYMPOSIUM ON CONTINUING MEDICAL EDUCATION IN MONTANA

SPONSORED BY
WICHE MOUNTAIN STATES
REGIONAL MEDICAL PROGRAM—MONTANA
AND
MONTANA MEDICAL ASSOCIATION

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WESTERN INTERSTATE COMMISSION FOR HIGHER EDUCATION

University East Campus, Boulder, Colorado 80302

January, 1969

The WICHE Mountain States Regional Medical Program is funded under Public Law 89-239, Regional Medical Programs.

Foreword

The major thrust of the WICHE Mountain States Regional Medical Program has been to develop continuing education programs for all health professionals involved with the treatment of heart disease, cancer, and stroke. For the past two years, the Montana arm of the four-state program has worked toward setting a climate for these professionals to identify their educational needs and to seek new ways of meeting these needs.

Shortages of manpower exist in all of the Montana health professions. This problem could be reduced through expansion of basic resources for training or through increasing the effectiveness of manpower now available. The primary solution in Montana, because of its lack of a medical school, its sparse population, and its remoteness, seems to be in upgrading the effectiveness of available manpower.

In Montana, the Montana Medical Association has assumed leadership in solving the need for continuing medical education. The Montana Regional Medical Program has cooperated in this effort.

In December, 1967, the Montana RMP State Advisory Subcommittee on Continuing Medical Education approved the study and development of a plan to provide continuing education for all health professionals. This was soon followed by a resolution to develop a full-scale program of continuing education.

In March, 1968, the Montana Medical Association gave its Executive Committee the authority to create a research and education foundation which would provide a full-time medical director to institute programs of continuing education for all health professionals. The entire program would be financed initially by a federal grant which would be an operational project of the Mountain States Regional Medical Program. The groundwork was thus laid by the Montana RMP and

the Montana Medical Association to establish the research and education foundation.

As one step toward creating an environment for state-wide coordination of continuing health education, the Mountain States RMP-Montana and the Montana Medical Association sponsored a symposium on continuing medical education on August 12 in Great Falls, Montana. This was an effort to bring health professionals into a context where they would begin talking together about interprofessional continuing education.

This report of the symposium includes summaries of speeches of the four consultants, Alexander S. Anderson, M.D.; M. Roberts Grover, Jr., M.D.; Earle Marsh, M.D.; and Dr. Laura O. Walker, R.N. Also included are general remarks on two general discussion sessions, "The Strategy of Interprofessional Continuing Education Development in Montana," and "The Development of a Plan for Continuing Medical Education in Montana," which focused on the proposed research and education foundation.

Over 150 participants attended the symposium representing 15 health occupations. This wide base of interest in continuing medical education is evidence that these practitioners have acknowledged the need to increase their capabilities and improve their professional competence in rendering patient care. It is the mission of the Mountain States RMP-Montana to provide the continuing education vehicle needed to attain these goals.

Frank L. McPhail, M.D.
Director
Montana/Mountain States
Regional Medical Program

Great Falls, Montana
December, 1968

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Continuing Medical Education--Problems, Priorities, and Plans

"A University of Oregon Medical School Experience"

M. Roberts Grover, Jr., M.D. *

A recent American Medical Association statistical report concerning continuing medical education courses shows a significant annual increase in the number of courses offered around the country as well as the number of registrants participating in courses. While these statistics are interesting, they do not tell if the fundamental goal of improving patient care is being achieved.

The question needs to be posed, "Are there patients who are not receiving the best available medical care because health professionals are not using the most recent medical knowledge?" If the answer is, "Yes," then the task is to find out why this knowledge gap exists. Appropriate information programs can then be formulated to close the gap.

Does a knowledge gap exist? This point has been discussed in continuing medical education circles for years, and millions of dollars have been allocated under Public Law 89-239 to close the gap. Most experts agree that there is a gap. In order to develop proper programs to solve this problem, we must know why it exists. There are multiple interrelated causes which contribute to the gap and will therefore require multiple solutions implemented by innovative plans. In my opinion, there are two general causes for this gap—one is student-related and the other is information-related. Let us examine these two causes in more depth.

Student-Related Causes of the Knowledge Gap

A prominent student-related cause of the knowledge gap is the tremendous professional, community, and personal demands made on a physician's time. Another cause is the lack of student motivation because of apathy associated with increasing age. In addition, many students consider learning a drudgery, particularly if their professional school training has been uninspiring and irrelevant to their needs. In some instances, the student is unaware that a knowledge gap exists

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*Dr. Grover is Associate Dean of the University of Oregon Medical School.

because of the explosive increase in medical knowledge, which makes it virtually impossible to keep abreast of all new advances. For those who do recognize that there is a gap, it is sometimes painful to expose their lack of knowledge to others, and they thus elect not to attend formal postgraduate courses.

Programs to Close the Student-Related Knowledge Gap

There are several possible solutions to problems associated with student-related causes of the knowledge gap. Since some students fear exposure of education deficits, it helps to design programs that stress informality in the learning situation. Indicate to the students that everyone including the "teacher" is in a position of sharing experiences that will be mutually beneficial. No one has the "final" answer. Small groups help facilitate an informal atmosphere, and a moderator trained to use group techniques can reduce learner tension.

For physicians "too busy" to attend courses because the courses are given too far from their homes, circuit continuing education programs can be used. The University of Oregon Medical School offers circuit courses in 18 communities in Oregon, Idaho, and Montana. Each program is 4½ hours in length, which is equivalent to the amount of time a physician might routinely commit each week for recreation.

Many busy practitioners would have time to continue their education if more paramedical personnel were available to assist them with tasks not requiring a physician's skills. This would mean that physicians would have to be willing to delegate these duties to other members of the health team and learn to function effectively as the leader of the team. Multidisciplinary learning experiences might provide a mechanism for accomplishing this goal. Interprofessional continuing education programs will be discussed in depth by the other speakers.

Information-Related Causes of the Knowledge Gap

There are several prominent causes of the information-related knowledge gap. The most obvious is the exponential increase in medical knowledge. Often this new information is poorly presented and diffuse. Because of this, it is difficult for the practicing physician to locate relevant information.

Another important cause is that appropriate teaching methods are not used to present formal postgraduate courses. The University of Oregon Medical School circuit courses are using several approaches that I would like to share with you. In order to plan a relevant course,

subjects have been selected by asking the following questions: "What do physicians want to know?" "How important is the disease?" "What is its incidence?" "What can be done to change morbidity and mortality?" "What are the ages of the patients most commonly affected by the disease?" "What performance deficits can be identified that need to be remedied to significantly alter the quality of patient care?" Input relating to these questions is solicited from both the students and the teachers.

Next, specific measurable course objectives are formulated. Then methods to implement the objectives are selected.

In Oregon, we have used three basic teaching concepts to help us to select the best methods.

1. The teaching method employed should be appropriate to the knowledge or the skill being taught.

2. Learning can be more effective if the learner is an active participant.

3. Learning is more effective if key points are repeated and emphasized.

For example, during the circuit course, case discussions are used to encourage student participation and to present situations which require decisions confronting physicians in the private practice situation. We avoid the "textbook" approach. The participants are divided into small groups of 10, and trained moderators lead the discussion. They do not answer questions raised by the group, but encourage the participants to find their own answers. To add to the realism of the case and encourage participation, students are asked to interpret X-rays, electrocardiograms, and pathological specimens. The group sessions also provide an opportunity for students to recognize their own knowledge gaps.

Following the small group sessions, a panel of faculty members discuss the same case and answer questions raised by participants. Important points are repeated and re-emphasized in the panel discussion and in xeroxed reprints given to participants.

Evaluation

Any education effort must be evaluated. Five basic levels of evaluation, suggested by Dr. Henrik L. Blum, are used to assess the adequacy of the circuit programs.

Activity Level

Evaluation at this level asks the question, "Is there a program operating and are the activities that were planned being carried out?" If one uses the circuit course as an example, one might ask, "How many courses have been given?" "How many students attended the program?" and "How many reprints have the students read?" This is a superficial level of evaluation, but it does provide some useful information.

Demand Level

This level of evaluation asks the question, "Is there a demand for the program?" Using the circuit course example, one might ask, "Are there requests from the communities to provide more than three circuit courses per year?"

Efficiency Level

This level of evaluation asks the question, "Are the results of the program being achieved at a reasonable cost?" Referring to the circuit course example, one could ask, "What is the cost of each program per student, and how does this compare with other methods of instruction?"

Effectiveness Level

This level of evaluation asks the question, "Are specific predefined program objectives being accomplished?" Again using the circuit course example, one may pose the question, "What percentage of physicians who attended the shock course subsequently use central venous pressure measurements to monitor patients in shock?" A program director can collect information to answer this question. It is vitally important to determine if specific measurable objectives are being achieved.

Appropriateness Level

This final level of evaluation asks the question, "Are the projects being implemented moving us toward our goal (to improve patient care)?" It is possible the project objectives can be achieved and yet not result in improved patient care. Using the circuit course example, physicians may be using central venous pressure monitors after attending the shock course, but doing this may not improve the morbidity or mortality of patients they are treating in shock.

In conclusion, it is obvious that closing the knowledge gap is a complex problem that requires multiple innovative solutions if we are to improve care given to our patients.

Can Health Professions Work and Learn Together?

Earle Marsh, M.D. *

The world today is in a constant state of flux and instability. Scientific inventions and knowledge have contributed greatly to this condition. Because of the knowledge explosion within the health sciences, it is impossible for a practitioner to know everything related to his health field. For this reason, he must approach his role as a member of the health team.

Around 1910, due to the lack of health manpower, the physician served the functions of physician, nurse, pharmacist, and dentist. For every 100 physicians in this country, there were only 40 allied health practitioners to ease the physician's load. As the demand for health services increased, the physician created a variety of jobs for health personnel. Today the ratio between physicians and allied health personnel is much more favorable than it was 50 years ago. Now there are approximately 1,200 allied health professionals for every 100 physicians.

Coordination Is Necessary

The problem no longer seems to be one of "manpower" as much as "mind power." The important concern is to train the existing persons to effectively perform their roles in the delivery of patient care.

The training of the professionals in the health team must be coordinated. The Montana interest in a medical education and research foundation exemplifies a concern for coordination of education for health professionals. Such concern is essential when one considers the importance of the health team in preventative medicine.

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*Dr. Marsh is Coordinator of the Allied Health Professions at the University of California Medical Center in San Francisco.

Prevention of Chronic Illnesses

In the United States, there are comparatively few epidemics. Most health problems are related to chronic diseases. With present therapeutic methods, it is possible to prevent 50 percent of such diseases. A vast number of persons in our society have limited access to health services due to geographical isolation, lack of information, and limited financial resources. If such persons were brought into a medical context, many chronic cases of arthritis, obesity, hypertension, and other illnesses could be prevented.

It is the responsibility of all health professionals to be sensitive to the patient's psychological and physical needs. Conscious, coordinated efforts must be made at every level of professional training and practice to insure that this responsibility is integrated effectively into the patient care process.

Communication Problems Affecting Patient Care

Laura O. Walker, R.N., Ph.D. *

Patient care is accomplished through a very complex process which is coordinated by many individuals with different knowledges, skills, values, and purposes. The coordination of this action requires extensive communication among the participants. Much evidence supports the idea that patient care in any given hospital or health agency is as good or as poor as the communication which exists among the health professionals in that hospital or health agency.

Communication is an essential channel of interaction among the health professionals. As these health professionals interchange messages, share perceptions, and discuss observations, their understandings are shared and validated. This interchange, validation, and agreement on a future course of action is crucial to the patient's well-being. Once agreement has been reached, active personal commitment by the participants is established. An implied expectation of a mutually gratifying outcome is developed and held in common. These feelings are essential to the delivery of quality services to the patients.

On the other hand, failure to communicate leads to frustration, to lack of commitment to the outcome, and to dissatisfaction with oneself and other health professionals. The reasons for failure to communicate tend to be many and varied, but they are generally more apt to be excuses than reasons.

Communication among the health professionals is one of the major factors determining the quality of patient care in the health agency. There seem to be three major considerations which make communication important for the delivery of health care.

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*Dr. Walker is the Director of the School of Nursing at Montana State University.

The Knowledge Explosion

Scientific knowledge of health and of human behavior has more than doubled in the past 50 years. The application of these scientific facts by the many different health disciplines expands the knowledge explosion beyond the comprehension of most of us. The result is that many different communication problems arise among and between health professionals, patients, and patients' families.

It is not uncommon for patients to receive different information from different types of personnel or even from the same type of personnel from different departments.

The patient sometimes fails to understand the meaning of the words we use, but he doesn't know that he didn't understand, so the misunderstanding is not corrected.

Doctors often delegate patient care responsibility to nurses, but there are few opportunities for the exchange of information between them. Such exchange is necessary to make the process fully effective.

Verbal orders and established routine procedures tend to develop habit responses rather than thinking responses, in which instance, misunderstanding and misinterpretation can easily arise.

Multiple Diagnosis of Illness

There are many communication problems implicit in the delivery of patient care services to the members of our society. The figures cited by Dr. Marsh referring to the high incidence of chronic illnesses indicate a communications gap between the health establishment and the public.

Quite frequently a patient is admitted to a hospital due to an acute or emergency condition. Taking his history is done under pressure of time with the patient under stress. The accompanying chronic illness may not be communicated, and severe patient care problems are precipitated.

The patient must be incorporated into the health team. Many patients are so well adapted to their particular chronic illness that we should take this adaptation into account in planning for patient care. The dietary adaptation of some cardiac patients is a common example.

Specialized Personnel

The third consideration is somewhat related to the first two. It is that the knowledge explosion, longer life expectancy, the problems of

aging and chronic illness, and our complex society have tended to produce many types of specialized personnel to deal with our health problems. There are many specialties within the field of medicine and many specialties now developing which are supportive to medical care.

The patients are subjected to a constant flow of hospital personnel. Each specialist conveys an air of business, and patients do not know how to request the assistance they need. As a consequence, patients tend to get both information and support from each other rather than from the staff of health professionals. This often results in misinformation and undue apprehension.

Suggestions for Dealing with Communication Problems

Physicians and nurses in key positions in hospitals and patient care agencies should take a careful look at what is happening to the patients in their agencies.

The people who are directly concerned with the delivery of care are well aware of the problems. However, the leadership and know-how for dealing with the problems need to be sanctioned and stimulated from the administrative level. Physicians and nurses must examine the three considerations: knowledge explosion, multiple diagnosis of illness, and number of specialists. These persons should examine the answers to the following questions:

Who talks to whom?

Do we differentiate between words, things, and actions?

How well do we use common aids to good communication? Does the staff use simple, clearly spoken words while communicating among themselves and with patients? Is there an appropriate pleasing environment for the patient?

The responses to these questions can be used to evaluate the communication networks, not only among the health professionals, but also as these persons relate to the patients.

It is important to remember that the role of improved communication is an adjunct to better patient care in hospital or health agency.

How Can An Interprofessional Program of Continuing Education Be Developed?

Alexander Anderson, M.D. *

The development of an interprofessional continuing education program in Montana is a sizeable challenge and an exciting opportunity. The words "challenge" and "opportunity" are purposeful choices because of two already-apparent characteristics of the program that will emerge. It will not be planned and administered from a medical center that is remote from the daily health care problems of your communities. It begins with the expressed need and interest of many members of the health practitioner community as evidenced by the attendance and professional representation in this audience today.

Continuing Education in Montana will be by necessity a "do-it-yourself" program. Usually the responsibilities associated with continuing professional learning are relinquished to medical centers, institutions, or agencies where program-planning is merely a parade of luminous names talking about their special interests and research efforts.

You have the opportunity to begin where continuing learning should begin—with a study of the health care problems you are encountering, the identification of the additional knowledge and skills needed to solve problems that are not being met, and the establishment of priorities and methods by which the needed learning can be gained. This is educationally sound, for learning is, and has always been, acquired through work expended by the student, and cannot be equated with the actions of the teacher.

The first step is scrutiny of one's own performance and the determination, with or without outside help, of what needs to be improved or altered. Learning for the sheer love of learning is a luxury for the

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idle. It becomes relevant and pragmatic when it is acquired to solve problems that are real.

The steps that are necessary to achieve an interprofessional program that is patient-centered are the following:

1. Review of health data, e.g., patient records, charts, biostatistics and registries, to determine the variety of health care problems prevalent in a community, clinic, hospital, or office.
2. The determination of what is now being done to meet these health problems.
3. The determination of what could optimally be done by utilizing available biomedical knowledge and skills.
4. The derivation from this information of educational priorities based on health needs not now being met and on the availability of medical knowledge that would make a difference.
5. The selection of the practitioner from among the available interprofessional pool in a community who could best acquire and apply the needed knowledge or skills.
6. The development of a learning opportunity for this individual or group of individuals at a remote setting or by importation of the needed experts or teachers to the community.

The methodology for establishing the content of such a program of self-directed study was reported by J. Williamson as an outgrowth of a demonstration project in continuing education for physicians in Rockford, Illinois.[1]

What has been described above is a method by which a self-directed program of continued learning can be established on educational needs derived from actual patient care problems. There is, however, a second essential feature of the program if it is to be truly interprofessional. The environment must be prepared which will enable people with training in the separate health professions to learn together.

Nurses, physicians, dentists, pharmacists, occupational therapists, and radiology and laboratory technicians are long accustomed to working with patients in relative isolation from colleagues or within a rigid hierarchical structure with ill-defined but sacrosanct responsibilities. They are not accustomed to the peer relationship required in a common setting for learning or for scrutiny of patient care to determine educational needs.

It is tempting to predict that this second factor will be your greatest impediment to the development of an interprofessional program of continuing education in Montana. This prediction is based on the observation of and conclusions from an interprofessional task force who met at the Center for the Study of Medical Education at the University of Illinois in 1966 to determine the desirability and feasibility of such an approach to continuing education.[2] The evidence they present confirms the desirability, but cautions the unwary regarding the feasibility, of such a learning relationship.

Their experience and that gained from subsequent workshops at the Center, on the problems of interprofessional communication and conflict, confirm that several factors impede the utilization of these resources for improved patient care. These factors are (1) the early fragmentation of formal professional training, (2) the isolation during work with patients, (3) stereotyped notions of the role and function of other professions, and (4) remarkable lack of knowledge regarding the actual skills and competencies of each other.

One recent approach to this problem at the Center has been the introduction of sensitivity and human relations training techniques with mixed professional groups in this area of conflict as has been previously achieved by the employment of similar training in business-management programs and at other educational levels. At present we have enough anecdotal evidence and personal testimony from participating nurses, physicians, dentists, students, allied health professionals, and administrators to support the value of these methods in the resolution of misunderstanding and the constructive use of conflict when it does exist.

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[1]J. Williamson, M. Alexander, and G. Miller, "Priorities in Patient-Care Research and Continuing Medical Education," **JAMA**, 204: 303-308 (April 22) 1968.

[2]**Continuing Education for the Health Professions.** Report of an Interprofessional Task Force, Center for the Study of Medical Education, University of Illinois, 1966.

The Strategy of Interprofessional Continuing Education Development In Montana

The following section consists of excerpts from a panel discussion about interprofessional continuing education. The four consultants participated as panel members: Alexander S. Anderson, M.D., moderator; M. Roberts Grover, Jr., M.D.; Earle Marsh, M.D.; Dr. Laura O. Walker, R.N.

- Specific objectives of continuing education must be designed before any relevant and effective continuing education program can be initiated.

- Members of individual professions must communicate before they attempt interprofessional communication. Each group must evaluate itself to determine what its role is and what inadequacies in education it must remedy. Such efforts to explore the boundaries of patient care at the several levels will permit coordination of these functions.

- Once role objectives at the several levels are determined, there is some benefit in training all kinds of health personnel together. Such coordination in the training will result in the common goal of effective patient care.

- Several techniques can be used to involve allied health personnel in small group educational programs. Any such programs must have a patient-centered focus. Each group member should be asked to identify his most important services for the patient. Thus, it can be determined who gives what, who overlaps, and what gaps there are in rendering service. The educational programs should then be designed to fill those gaps.

- In patient-centered education, the patient's attitudes should be integrated into the continuing education program. He must be educated regarding health care effectiveness and be asked to determine gaps in the care delivery.

- Once practitioners have identified the patient's health needs, they are in a better position to decide who should meet the need, and ultimately, how the practitioner should be educated to fulfill the need.

- The physician must learn to delegate authority in the performance of patient care. A great deal of energy is spent by health practitioners obtaining and maintaining status and prestige. This energy should be channelled toward efforts of communicating the competencies of each member of the health team and integrating these members into effective performance where each does what he can do best. This requires the patient's understanding and willingness to accept professional assistance from health professionals other than the physician.

The Development of a Plan Continuing Medical Education In Montana

A group of Montana health practitioners discussed the proposed Montana Medical Education and Research Foundation. The panel members were F. John Allaire, M.D., moderator; Esther R. Lantz, R.N., M.N.; Richard C. Ritter, D.D.S.; Thomas Underriner, M.H.A.; Francis Wright, M.T. The following is a summation of highlights of the session:

● The Medical Education and Research Foundation, proposed by the Montana Medical Association, is envisioned as an agency to coordinate all state-wide continuing medical education programs. A full-time director for continuing education will be selected as soon as funds can be obtained through the WICHE Mountain States Regional Medical Program. The Foundation will work with the state Comprehensive Health Planning Program as well as with the Regional Medical Program.

● The concept of a foundation was developed through meetings of a health practitioner task force which agreed that a need exists for continuing education programs. The group consisted of a dentist, physician, nursing educator, physical therapist, MSRMP staff member, and an administrator of education. Each member examined the need for such programs within his own profession and how these could be coordinated with all other health professions.

● In the proposed Foundation, the physician educator-director will work closely with all health professionals. Representatives of each profession will form planning groups which will be involved in developing course content.

● The entire field of technology, including computers and automation, appears to be a mandate for continuing education. Even with such technological sophistication, qualified personnel must be available. Technology can be helpful in delivering knowledge and skills through such teaching aids as tapes, films, television, and coaxial cable trans-

mission. But these aids are not the principal ingredient in education; the human element is.

- Education programs must be built to insure communication because of the continuous expansion of existing health occupations and the development of new technological skills. The demonstrated support for the proposed Foundation will help bring cooperation and communication to the program of continuing education.

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